Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Stakeholder Input Process

General Stakeholders Meeting #4

Tuesday, October 25, 2005 – Sacramento
Wednesday, October 26, 2005 – Los Angeles

Meeting Summary
For Discussion Only

A. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed, culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

The general stakeholder meetings on October 25 and 26, 2005 were the fourth set of general stakeholder meetings for the MHSA. The October 25 meeting in Sacramento and the October 26 meeting in Los Angeles used the same agenda to provide the opportunity for stakeholders to review the status of the MHSA, to learn about progress on the Constituency Outreach and Education Collaborative (COEC) and the Network of Care.

Ninety-four people attended the meeting in Sacramento and 61 attended in Los Angeles for a total of 155 stakeholders. This summary reflects the combined content, questions and comments from both the October 25 meeting in Sacramento and the October 26 meeting in Los Angeles.

Meeting Purpose

The purposes of the general stakeholder meetings on October 25 and 26 were to:

1. Reflect on the first year of the Mental Health Services Act.
2. Identify progress and challenges of the first year of the MHSA.
3. Identify progress on implementation of the Constituency Outreach and Education Collaborative (COEC).
4. Learn about the Network of Care.

B. Welcome, Introduction and Purpose of the General Stakeholders Meeting

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, welcomed participants to the fourth set of general stakeholders meetings. She described the purpose of general stakeholder meetings: to update the community about progress on MHSA at the state level in the previous three to four months. Ms Wunsch added that there have also been 14-15 workgroup meetings in which people with particular interest, experience or expertise on specific MHSA components or topics, have provided input on specific questions about those areas (e.g., cultural competence, community services and supports (CSS), performance measures, capital). Prior to past workgroup and general stakeholder meetings there has been a pre-meeting specifically for consumers and family members. Because of the MHSA Oversight and Accountability Commission (OAC) meeting in the afternoon of the October 26 meeting in Los Angeles, the client and family meeting was not held in either location.

Ms. Wunsch welcomed Rose King, a tireless advocate for mental health, who had the original idea twenty years ago, based on polling data, to create an initiative for mental health.

C. Celebrating MHSA's First Year – Acknowledgements and Reflections

Rusty Selix, Executive Director of the California Council of Community Mental Health Agencies, who was a primary force behind the vision and passage of Proposition 63, reflected on the first year of the MHSA. He noted that the eyes of the nation are on California, as states throughout the country are watching the progress of the implementation of the MHSA. The rest of the country marvels that California passed a tax to fund mental health services.

In terms of MHSA progress, Mr. Selix acknowledged that a year ago he would have been shocked had he been told the CSS program was not up and running by now. However, in this first year, stakeholders have learned that it takes time to transform the system from the old "fail first" system to the new "help first" system. He noted that the recent tragedy of the woman who threw her three small children into the San Francisco Bay embodies the challenges of the old system. Released from hospitalization with a

30-day supply of Halidol and nothing else, it should be no surprise that she went off her medication after the month's supply ran out. Living in a homeless shelter with schizophrenia and three children was a recipe for disaster. Her parents went to Child Welfare, concerned about their daughter and grandchildren. CPS however, while appropriately saying that schizophrenia is not a reason to remove children, seemed to provide no support to the woman or her family. The framework for failure was there. This is the system the MHSA is working to transform.

Then Mr. Selix provided his assessment of the last twelve months of efforts towards MHSA implementation. He believes that on a scale of 1 to 10, the process rates an 11. DMH is learning what the community wants. The authors of Prop. 63 looked at the Prop. 10 Initiative, which created totally freestanding entities in each county, separate from other children's groups. Mental health advocates wanted to transform the whole mental health system.

Stakeholders are all students in the first year of transforming the entire mental health system. It is like starting college with a multi-year curriculum. Not everything is perfect; we are only at the beginning. It is important to identify areas for improvement while recognizing how much good has been done so far.

According to his grading system, everyone involved in the process has earned an A+.

- The Governor earns an A+ for his state budget, which did not divert the mental health budget, choosing instead to respect the will of the voters. In addition, his appointments to the Oversight and Accountability Commission comprise a high caliber group of people. Advocates requested that members have personal experience with mental health, and twelve of the sixteen commissioners do.

- The Legislature earns an A+ because they too left the mental health budget untouched. They talked about doing so, but it was never a serious issue. Several policy bills were introduced which, after working together with advocates, complement the MHSA.

- DMH gets a huge A+. It is amazing how well DMH has adapted to the changes. The Department is both nimble and open to change, which is remarkable for a government agency. Staff recognize that this is a once-in-a-lifetime opportunity to do something we can all be proud of. The values document, which was among the first documents circulated to stakeholders, stated that the core value was the central role of consumers and family members. DMH successfully put that value forward and conveyed its importance to the counties through the CSS planning process. Leadership and cooperation have been important. There were some disagreements during the process as there should be and they have been handled with sensitivity and openness.

- County mental health directors get an A+ for fully embracing the transformative process. Advocates were concerned across the state that the decisions would be

made behind closed doors and these concerns seem to be universally unfounded. Throughout the state, the planning has embraced the MHSA values. The county mental health directors also have trusted the process, providing leadership, encouraging broad involvement. In the past year, tens of thousands of Californians have participated in their local planning processes: in Los Angeles County alone, 10,000 people came together. The money seems to be well-spent on the integrated services Prop. 63's authors envisioned: services based on the AB 2034 program for adults and the Children's System of Care (CSOC) for children, programs that maximize recovery and resiliency.

- County Supervisors get an A+. Not a single county has tried to supplant the funding. It is healthy to have the debate: it shows we can get through these issues and stay united as a community. They have given their support, despite pressures from county administrators, district attorneys and law enforcement. So far the Boards of Supervisors have supported the will of their county stakeholders.

- The MHSA Oversight and Accountability Commission gets an A+, although it is only a few months old. It has striven to avoid the superficial, with the attitude "Let's not be a mile wide and an inch deep." They are holding a hearing on housing on October 26. The housing issue is a huge issue for mental health consumers. In the past, housing developers have been reluctant to establish affordable housing for people with severe mental illness because of the supportive services needed to help people stay in housing. The MHSA provides the opportunity to fund supportive housing. The housing community is now looking to the MHSA, because not only can we provide the support services but also we have funding for housing itself. There could be a billion dollars in housing bonds for the homeless mentally ill. This would leverage MHSA funding, so that every dollar spent would leverage $2 of other money to potentially build 20,000 housing units. This is beyond anyone's dreams.

- The biggest A+ goes to the mental health community. People statewide are taking the time to do this work.

There is still a long way to go. The MHSA is like a one-year-old child. It still has a lot to grow. There will be peaks and valleys. There will be some glorious years and some painful years. The stakeholders are the stewards for this system, this system that will truly benefit people who are just being born today. Twenty years from now, there will be multiple billions of dollars in the MHSA accounts. MHSA will account for 40-50% of the mental health budget. The current $300 million for CSS will be $3 billion then.

The biggest challenge is that 40 cents out of every dollar for services is spent on paperwork, which makes it harder to retain staff. In addition, mental health funding is only serving half the number of people it could be. The changes expected in information technology and the thoughtful development of outcomes measures will reduce some of the burden. An automated system of accountability is needed. It is unfortunate that every county has taken the maximum 15% of the money for

administration. While it may be necessary, it takes away from treatment and other services.

The potential of prevention and early intervention is exciting. Collaborations must be built with schools serving children from birth through higher education. Primary care has to be a central part of MHSA collaboration, particularly in ethnic communities that may not recognize mental health as an issue. Private health insurance providers must be involved and must pay for behavioral health benefits and services for their members. Employers, the business community and labor must also be involved.

The MHSA has had a great first year, and gives hope and confidence that future work will be successful.

Mr. Selix then shared a birthday cake for the MHSA's celebration.

Stakeholders Comments and Questions

Questions

- Does Prop. 76 pose a threat to the MHSA?
  - ***Mr. Selix Response:*** Prop. 76 is the "live within our means" budget initiative. It is not a direct attack on the MHSA, but it changes the way the state budget is done. It uses averaging over three years to determine how much will be spent. MHSA collects money differently. If Prop. 76 passes, it has the potential to do damage to our ability to use the money raised.
- My county has allocated about half the CSS funds to community-based non-profit agencies. In some states, a lot of services have been turned over to community-based organizations (CBOs) to reduce costs, but that reason has vanished, as the CBOs have raised their costs. Is California in danger of that?
  - ***Mr. Selix Response:*** It will be necessary to look provider-by-provider, county-by-county. However, in general, CBOs cost about a third less than other contractors.

Comments and Reflections about the MHSA's First Year

Inclusion and Outreach

- Congratulations to all who have worked so hard in your counties and have done such a good job of outreach to stakeholders. Let us continue to work to maximize the outreach, to continue to include these people in an ongoing process.
- Family members have finally been given a voice in the process.
- Ethnic services staff are part of the process, which brings such delight.
- Stakeholders as a whole earn an A+ for our learning curve, especially for inclusion. Not everyone is included yet, but much more is known about including them as the process moves forward.

- The stakeholder process has been a very instructive and informative process. Our county is struggling with what exactly is a system driven by clients and family members.
- Look at how many new friends we have all made during this stakeholder process. Now the meetings have standing room only. Stakeholders are learning to know each other. It feels like a reunion today.
- The pulse of the consumers is celebratory, but consumers also feel struggle, anxiety, concern and fear. How is it possible to change things when the people in charge are the same people in charge of the old system? This first year is not all a "10 pointer." It is still a struggle with concern about where things will end up. Consumers will keep being involved in this process, pushing for transformation.
- It has been a very exciting year, with new focus on consumer and family member employment and more shared knowledge of the importance of consumers and family members. This process has touched a lot of people, but when it comes down to putting word to paper, not everyone is involved. There is still a lot of room for improvement. There is still a long way to go.

Change within the Government

- There have been many positive changes and the DMH staff has been very positive about moving toward the recovery model. Things are moving quickly in the right direction.
- DMH has asked questions of the counties that they have never been asked before. The OAC is interested in hearing the bad news as well as the good. Commissioners want to know the context for the MHSA: what is the picture of mental health services today?
- DMH, Carol Hood and her staff deserve an A+ for the lightning speed and care they have put in so far.
- We have not seen the change in our county.
- There has been a continual push to delay implementation because "we need to study it." This is not true: many CBOs already know what the problems are. Give them the money and let them work.

Needs

- A large majority of clients want to know what the MHSA is really doing for them. At this point, San Francisco County has a plan. The process has been very open. Clients want to know how the money is being spent for their mental health needs. Clients are looking for more money for recovery programs and are pushing for MHSA money to be spent for mental health needs only. It is clear that DMH supports this.
- Private providers need something done about the amount of time spent on paperwork and audits as well as a multi-cultural workforce. For those workers who do not speak English as a first language, paperwork requirements are additionally burdensome. This needs to be addressed.
- As both a family member and a client, the only way to make a difference is to work together in unity. We must protect family members and clients, children and seniors, transition-age youth and adults. There will never be enough money; it is how we

work together, how creative we are that will make the difference. This is a beginning. I do not like the fighting. I am proud to be here advocating and proud of the work we have all done.

- It is essential that the rest of the system be transformed. Use this update process to emphasize the need to do strategic thinking. Look at the smartest way to use the full service partnerships, continually evaluating the appropriate level of services needed by any individual. People with mental illness should always have access to the full service partnership, but the level of service should decrease with recovery. Divert money from high-end hospitalization to full service partnerships that will evolve into less costly peer supports at later stages.
- Service Employees International Union (SEIU) thanks everyone for allowing SEIU to be part of the process. Three years ago today Senator and Mrs. Paul Wellstone died. They were working for legislation concerning mental health parity, which still has not passed or been signed by the President. The MHSA is exciting as it transforms the system for clients, family members and workers. It is important for workers to have a voice so they are able to move forward with the clients and family members.
- People in the stakeholder process who have been very involved discover that something must be done about the adult system. Adults enrolled in a full service partnership will get amazing care. The rest receiving services will be a second tier, inequitable system.
- Clinics have $50-$80 per month to spend on the care of the uninsured people in the second tier. It is only somewhat better for Medi-Cal clients: there is $200 per month to spend on their care.
- By not funding the Children's System of Care, DMH is not abiding by the Maintenance of Effort requirement. CSOC is the best way to serve children.

D. MHSA Progress and Updates

Carol Hood, Deputy Director, and DMH staff then discussed the progress of MHSA from the Department's perspective. Tina Wooton began by reading "Lessons from the Geese" by Robert McNeish, which she shared as an inspiration about the community process:

- As each goose flaps its wings it creates an "uplift" for the birds that follow. By flying in a "V" formation, the whole flock adds 71% greater flying range than if each bird flew alone.

  Lesson: People who share a common direction and sense of community can get where they are going quicker and easier because they are traveling on the thrust of one another.

- When a goose falls out of formation, it suddenly feels the drag and resistance of flying alone. It quickly moves back into formation to take advantage of the lifting power of the bird in front of it.

Lesson: If we have as much common sense as a goose, we stay in formation with those headed where we want to go. We are willing to accept their help and give our help to others.

- When the lead goose tires, it rotates back into the formation and another goose flies in the point position.

  Lesson: It pays to take turns doing the hard tasks and sharing leadership. As with geese, people are interdependent on each other's skills, capabilities, and unique arrangements of gifts, talents, or resources.

- Geese flying in formation honk to encourage those up front to keep up their speed.

  Lesson: We need to make sure our honking is encouraging. In groups where there is encouragement, the production is much greater. The power of encouragement (to stand by one's heart or core values and encourage the heart and core of others) is the quality of honking we seek.

- When a goose gets sick, is wounded or shot down, two geese drop out of formation and follow it down to help and protect it. They stay with it until it dies or is able to fly again. Then, they launch out with another formation or catch up with the flock.

  Lesson: If we have as much sense as geese, we will stand by each other in difficult times as well as when we are strong.

Then Ms. Wooton recruited new members to the Client and Family Member Expert Pool. This pool assists DMH in helping the Compliance Unit to do site visits, provide information on peer support and now as a part of the CSS proposal review teams. In June, DMH's Client and Family Member Task Force decided to expand the Expert Pool, for which applications were available at the general stakeholders meeting and can be found online. Members are paid $10 per hour for their participation as well as per diem and travel. People who want to join the Expert Pool, but do not want to be on the CSS review teams can apply at any time. People who do want to be on the CSS review teams need to apply by November 1, 2005. Contact information is in the packet. Ms. Wooton encouraged people to apply and to share the information and application with friends and family.

Staff then announced that DMH is actively recruiting for many openings for Associate and Staff Mental Health Specialists within the Department. Packets of information were also available at the meeting and online. These positions have no deadlines for application. The Department wants to hire as quickly as possible. As an example, the Systems of Care section, one of four sections in DMH, has 30 vacancies within a section of 110 staff. This recruitment process is evidence of considerable transformation. Typically, DMH administers tests every two to four years, creating a list that is then used until the next test, years later, is administered. Now, testing will occur

several times a year, to keep refreshing the list and offering employment opportunity to a wider range of people.

Ms. Hood then announced that DMH is searching for a person to head the MHSA component of Education and Training. The eligible person must already be in state or county employment.

She next provided an update on progress of MHSA based on a PowerPoint presentation, "Celebrating Transformation and Mental Health Services Act." The update included:

- Celebrated efforts
- Status of components
- Collaboratives at the State
- County plan updates
- Planning for the future

Celebrated Efforts

- Process
  - The process has been inclusive and transparent.
  - A major success of the process has been the involvement of consumers and family members in the development of draft products, design of the review process and the review process itself.
  - Over 3,300 participants have taken part in workgroups and conference calls.
  - There have been 45,642 hits on the DMH/MHSA website since February 2005.
  - DMH polling about community participation to date has revealed that at least 49,000 people have been involved in just half the counties contacted so far.
  - There are approximately 1,000 subscribers to the MHSA mailing list.

- Promotion of hiring consumers and family members is a DMH priority.
  - DMH included in the MHSA three-year requirements that counties include strategies to expand peer support services.
  - MHSA training for county mental health staff includes the recovery model.

- Cultural competence: DMH recognized the existence of substantial disparities in services among different ethnic groups as well as concerns that services were not welcoming to different groups. DMH articulated a need to make the system much more responsive to the needs of all Californians.

- Short Term Strategies: When it became clear that services were not going to be implemented by January 1 or July 1, stakeholders asked DMH to start some programs quickly, so that voters and stakeholders could see that the process was underway. As a result, two initiatives were funded: the Constituency Outreach and Education Collaborative (COEC) and the Network of Care, both of which were discussed later in the meeting.

Status of Components

- CSS
  - DMH is reviewing county plans and requests for start-up funding.
  - DMH is developing emergency regulations. The Department is working with its lawyers to create a way to develop regulations that can adapt as the system adapts.
  - DMH is continually developing Frequently Asked Questions (FAQs) to clarify requirements for the website.
  - The Performance Measurement Advisory Committee is working on key event tracking similar to AB 2034 tracking as part of the evaluation process.

- Education and Training (Workforce Development)
  - Recruitment for a lead DMH staff person is underway.
  - A technical advisory committee has been selected, although it has not met.
  - Before funding can be disseminated in this area, there must be a needs assessment and five-year plan based on the assessment. Before that can happen, a Request for Proposals (RFP) for the work must be developed.
  - More immediate strategies, paid for with other components of the MHSA include funding for scholarships for the California Social Work Education Center (CalSWEC) and employment of clients and family members.

- Prevention and Early Intervention
  - Lead responsibility for this component has been assigned within DMH.
  - Currently, DMH is focusing on obtaining resources and background information. The process of creating approval for positions has taken time.
  - Work is underway on the vision and basic components. This will be both exciting and overwhelming. Eventually funding will be multiple billions of dollars, and will have a huge impact.

- IT and Performance Measurement
  - An advisory committee meeting was held on October 25.
  - The committee has the task of looking at technical elements to modify the existing system.
  - A primary focus of this component will be on electronic health records (EHR), which will increase accountability and decrease paperwork. DMH is committed to having accountability for outcomes, to make sure programs are effective. DMH staff clearly hear stakeholders' concern about the burden of documentation. Unfortunately, in the short run, the burden of documentation could get worse before it gets better.
  - The advisory committee for performance measurement is also focusing on ensuring that the counties and DMH have the capabilities to document outcomes.

- Capital Facilities
  - Staff are receiving input on a draft concept paper and developing draft guidelines. It is on the back burner for now until the costs for electronic health

records have been determined. Both housing and IT are funded from the same money and the priorities must be worked out.
  - The main focus for capital is on implementation of the Governor's Initiative to End Chronic Homeless. The critical players in putting together housing funding in terms of capital, operating expenses and supportive services – State Departments of Mental Health, Housing and Community Development and the Housing Finance Agency – have been told to coordinate efforts to leverage housing and services funds. They are issuing a single RFP.

- Collaboration
  - DMH gave funding to the State Departments of Education, Rehabilitation, Social Services, Alcohol and Drug Programs and Health Services in order to foster collaborations and promote the vision of the MHSA.

County Plan Updates

- Seventeen counties have posted their plans on the DMH website. These can be found at http://www.cimh.org/mhsa.cfm.

- Four counties have submitted their final plans to DMH: Fresno, Lassen, Los Angeles and Stanislaus.

- DMH is doing a meta-analysis of the plans concerning where money is being allocated in terms of age groups and funding type.

- Planning Process
  - Reviewing CSS plans is the main priority for the next few months, in order to allow rapid implementation of services.
  - Counties have to be responsive to the requirements: the core concepts of community collaboration, cultural competence, client and family member driven, wellness focus and integrated services.
  - DMH staff are trying to determine what is good enough in terms of the submission. When should DMH say it is good enough to move forward and when should it ask for more information? DMH is absolutely committed to transformation, and does not what to be so bureaucratic to cause frequent revisions. DMH is looking for a balance to move services to implementation.
  - One possibility for approval is an incremental process: individual work plans that can be approved easily may be allowed to move to implementation while discussions continue about other components of the county CSS plan.
  - Review teams include representatives of consumers and family members, cultural competence experts, experts in county mental health management (including retired mental health directors) and DMH staff in a variety of policy areas.
  - CSS plans will also be reviewed by the OAC and the Mental Health Planning Council for education and training issues.

- Preliminary Feedback
  - Local involvement of unserved and underserved is having significant impact. People have been surprised about the power of the stakeholders' process. People expected decisions to be "done deals" but the process has powerfully changed perspectives and decisions, especially among county mental health directors and staff.
  - Some groups do not feel sufficiently included yet. These include Native Americans, the gay, lesbian, bisexual and transgender community, survivors of torture (immigrants or refugees) and the deaf and hard-of-hearing community. DMH and counties need to develop outreach and engagement strategies to bring these groups into the process.
  - Community "ownership" of local CSS funding plans is high.
  - Local processes were overwhelming and many thought it was worth the effort. Some think it should be streamlined.
  - The CSS plan:
    - The logic model was helpful and should be maintained for the other components.
    - The plan requirements were too complex, making it difficult to write and not very readable when completed.
    - Counties are at different stages of submission. The lack of a hard due date helps to accommodate that.
  - Next steps and current challenges:
    - Significant need for workforce training and retraining.
    - Need to develop infrastructure, including finding adequate staff at the state and county level.
    - Need human resources to implement the changes.
    - Need to continue to clarify roles and responsibilities, such as: what are full service partnerships exactly? What does it mean to have a client and family member-driven system?

Planning for the Future

- Upcoming MHSA Regional Trainings:
  - Southern Counties: October 27 and 28.
  - Bay Area and Central Valley: November 9 and 10 at San Mateo Marriott, 1770 S. Amphlette Boulevard, San Mateo.
  - For further information on these and other upcoming web-based training sessions, visit the CIMH website at www.cimh.org.

Stakeholder Comments and Questions

Questions

- Considering the lack of a trained workforce, why was there a reduction of the California Social Work Education Center (CalSWEC) scholarships? Because of the reduction in scholarships for CalSWEC from 900 to 200, there will not be enough trained people in the pipeline. During the county planning process, unserved ethnic communities were awakened to the knowledge that services would be available.

Once people are awake to this fact, they will come knocking at provider doors and there will be no one to serve them. Two hundred students for the whole state is almost nothing.
    - ***DMH Response:*** The MHSA requires a needs assessment and five-year plan before the money is spent. The Department is looking for other sources of funding for CalSWEC scholarships because we do not have the authority to spend Education and Training funding. This is an important issue. DMH was concerned about starting a large initiative without the MHSA-required needs assessment and five-year plan. It was also very expensive per student. DMH needed to make sure that the cost per student was appropriate.
- In terms of one-time funds requests for CSS, Los Angeles County submitted such requests along with the three-year plan. There is a plan to establish an Asian-Pacific Islander client support group. When will the county hear about this?
    - ***DMH Response:*** There are different kinds of one-time funds: to expand the planning process; to kick-start additional programs such as training or consumer groups, both of which should have a two-week turnaround; and capital, which might have to wait until the plan is approved. In your county, DMH needs to understand the requests.
- Clarify the housing funding. While DMH has $3.1 million, are the counties expected to use their own money?
    - ***DMH Response:*** There is some state money, but this is not nearly enough to meet the need. DMH was allocated 5% of MHSA funding for administration. Because this is more than is needed for administration, DMH has chosen to put the money into other initiatives for the MHSA. Housing is one of these. Of the $3.1 million in MHSA funds for housing, it is expected that $2 million will be spent for services, $700K for the organizing body, and $400K to support the development of infrastructure. This is not enough to meet the need statewide, so counties may eventually need to add additional funding to meet housing needs.
- Who will review the CSS plans?
    - ***DMH Response:*** A senior staff person will lead a team of ten people, including clients and family members, and experts in cultural competence, children's policy, adults' policy, and county mental health administration.

Comments

- Involve clergy in the process. This is important especially for the Asian community, which often turns to shamans, priests and pastors before anyone else, including doctors.
- Ensure that services are responsive to the needs of the clients.
- The California Network of Mental Health Clients wants to be sure that clients and family members are included in the plans in terms of staffing and work.
- It is great that cultural competence issues are definitely being included in CSS plans.
- Evaluate whether trainings have been effective: who was trained, what they learned and how the trainees have used what they learned. Measure training outcomes.
- Thanks to Carol Hood who keeps her smile despite everything.

E. Feedback on the MHSA Stakeholder Process

Stakeholders provided DMH with feedback about four key questions concerning the stakeholder process itself and ways to maintain momentum for the MHSA in the coming years. They specifically answered the following questions:

1. What are the strengths of the MHSA stakeholder process so far?
2. What areas of improvement can you suggest for the MHSA stakeholder process?
3. How can annual CSS updates be used to maintain the momentum of the MHSA moving forward?
4. What other suggestions do you have to maintain the momentum of the MHSA moving forward?

1. What are the strengths of the MHSA stakeholder process so far?

The Process

- Requirements to have county- and state-level stakeholder process
- Many different ways to give input in the process
- Chance to discuss and hear other issues
- Helped to clarify issues in mental health process and viewpoints and generated ideas
- Everyone has opportunity to comment, outside of county filtering system. Keep outreach to local stakeholders.
- Lots of flexibility built into the process
- Flexibility of DMH and stakeholders
- The various meeting times, days, cities, weekends helped many people to participate
- Small group discussions
- Helped to get us out-of-the-box
- Creating a safe environment
- Creating more transparency (understanding of process), but not quite there yet
- Funding moving in right direction

Collaboration

- Collaboration has been huge
- Community is being built; people are being brought together, clients and family members, children's advocates, etc. with DMH. The community is growing.
- Our community has expanded
- Much bigger group of people who appreciate data helps to inform discussions
- Breadth and depth of consumer and family member involvement and cultural groups that never participated before

Inclusion

- The more inclusionary we are, the more helpful, the less in-fighting
- DMH has included family members and consumers. Solidified process that is way overdue.

- Inclusion of and outreach to consumers. DMH has been trying to reach out and trying to get feedback at all levels.
- Attempt to include as many people as possible and really try to listen. DMH modeled it and included in CSS requirements that counties include a broad array of communities.
- Bringing in new people from the larger community. The level of participation has been phenomenal.
- More voices heard
- Attempt to involve all of the relevant stakeholders
- Interaction with different stakeholders; not traditional hierarchy
- At first I was not willing to speak. Now I do and they listen. I am even drafting information.
- Meeting people we never would have met from all walks of life

The Guidelines

- We have core values and a noble cause. This has helped contribute to the momentum.
- Insistence on broad stakeholder involvement
- By identifying "clients" and "family," it helps us diminish and address stigma issues
- Encouragement to go slow and be thorough and thoughtful
- Introducing incremental approvals
- Comprehensive needs assessment; four age groups/needs
- Guidelines are clear when they come out
- Flexibility of funding to do new things

State Process

- DMH set the bar high for what the counties are doing
- DMH's speed of implementation
- Maintaining a positive decorum
- Holding general stakeholders meetings in both Northern and Southern California
- Many opportunities for audience to speak, not always true at local level
- Continue the process. It has worked well at the state level.

Leadership

- State has taken more leadership. This helps counties move forward.
- Raising the expectation that change could happen
- Leadership: get to know people; consistent people leading the process
- Carol Hood is a strength: clear and easy to work with
- Particularly strong leadership of Carol Hood
- John Ott's ability to manage consensus building

DMH Responsiveness

- Stakeholder input was incorporated into the plan requirements
- Consumer input feels good, promotes positive self-image and makes consumers feel valued

- Willingness to change when input is provided
- DMH response to feedback
- Response time of staff to return calls and emails
- When people question DMH or county mental health, they receive answers. Transparency has been real.
- Comments have been included in meeting documents and subsequent policy letters.
- Good listening
- Listening to consumers and family members

Cultural Competence

- Cultural diversity is inherent in the process and allows for differences in counties
- State has had a better response to Native American communities. Often tribal peoples get marginalized.
- Community involvement in ethnic communities
- Awareness of barriers (e.g., language)
- Broad in identifying the needs of different populations (cultural competence)

Communication Methods

- MHSA website is very good
- There are many types of opportunities: phone, web, conference calls and meetings
- Use of website has been helpful in updating communication
- Internet postings and email announcements of new positions
- Complete source of information on the Internet
- Communication, email and website
- Distributing information quickly and effectively, especially via the website
- Information dissemination
- List serve is great
- County plans are available to view

Training

- Training and planning/expanding outreach
- Understanding systems better

Local Process

- Stanislaus County consumer network does outreach to new consumers and goes to the small outlying areas to seek people out
- Consumers in the counties are heard
- County process is demanding but very inclusive and comprehensive
- County process broken down by age group allows for greater expertise. At the same time a group like law enforcement has a problem being represented at all age groups.
- Calaveras Mental Health has not been consumer-supportive but it has now hired two consumer staff
- County experts are in a position of anxiety with the paradigm shifts

2. What areas of improvement can you suggest for the MHSA stakeholder process?

Inclusion Issues

- Need to continue to outreach to other individuals. Include new individuals.
- Need to continue outreach to family members
- Need greater outreach for DMH stakeholder meetings
- Need expansion of methods employed to reach out to people
- Over-representation of certain groups vs. others
- Why are there no community providers reviewing the CSS plans? They are stakeholders too.
- Involve consumers/family members in State DMH
- More consumer involvement. Mental Health Department needs to support NAMI involvement. Multiple meetings with the Calaveras Director have not led to positive results.
- More outreach and advertising to reach more consumers
- Use appropriate language and peer groups to reach out to the underserved
- Outreach to unserved and underserved
- Difficulty of working within a bureaucracy and opening up process to stakeholders
- Need to include clients with other funding sources besides SSI and Medi-Cal

Collaboration Issues

- Not certain if we have achieved transparency yet
- Need more communication and collaboration between school districts and counties
- Need more involvement of private providers. Who is missing and why are numbers possibly dropping?
- Need greater inclusion of criminal justice system
- Need to determine how other departments (medical, criminal) fit into transformation
- DMH should build effective coalitions to ensure effective input
- DMH should develop model for collaboration
- Need more outreach to state departments to pass on information to their members or constituents
- My county has not engaged the educational system to help serve children and youth. We need administrators, principals and teachers. Need to focus with them on the prevention and early intervention component.
- DMH did not engage critical partners outside the mental health system, such as law enforcement, fire, education and health
- Expect different responses in different parts of counties by law enforcement
- Need more involvement of business community

Consumer and Family Member Input

- Consumers and family members need to be involved in the initial drafting of the plans

- Process usually started with draft document. It would be good to get some stakeholder input prior to writing draft document, like the model used with capital facilities process.
- Involvement of consumers and family members in the actual writing of the plan and budget narratives
- Integration of stakeholder input and drafting of the county's CSS plan
- Lost in translation: the county plan when completed does not reflect what stakeholders submitted
- There are some feelings that not all proposals were heard
- Need more inclusion of individuals' comments being recorded and shown in the plans
- Need inclusion in later stages of decision-making. Do not just take initial input, but continue the process.
- Continue to hire client and family members at all levels and use peer-to-peer approach, to encourage and include in decision-making process. Ensure continued involvement and voice by consumers and family members.
- Use consumers and family members other than tokens to demonstrate involvement. Consumers not allowed to participate at local policy level. County hand-picked whom they wanted.
- How will DMH recognize tokenism?
- Many counties are still not including consumers and family members

Training/Human Resources Issues

- Need more clients and family members working as paid staff, and need to prepare and train professional staff to work with them side-by-side
- Need retraining of professionals from consumer and family members
- Training for county counsels, county mental health boards and Boards of Supervisors
- Some notices of training opportunities come out too late for participation
- Need to put highest priority to workforce recruitment, training, and retention
- Need competitive pay rate (more than $10/hour) for consumers and family expertise
- Need to increase number of staff
- There have been reductions to resources for training new staff
- Need a more conscious effort to involve current line staff. A gap exists between leaders and line staff.
- Quality and availability of training for participation in the stakeholder process
- The whole family needs to be educated and their needs addressed

Communication Issues

- Need to more clearly explain stipends to consumers and family members, especially in terms of the effect of stipends on SSI payments
- Need brief information for the layperson and new participants, for example, FAQs and glossaries of terms and acronyms
- Need more use of video conferencing or ways to bring people in from remote areas of the state

- Have computer labs at counties for consumer and family member access to web information if possible
- Have a hard copy available of information on the Internet
- Need more support for access, including transportation, participation and maybe web casts
- When things are not put in writing, it is not as helpful. Meeting summaries of various workgroups have been done, but much information is lost. The chair of the workgroups might give updates.
- Respond to questions as needed
- Need better interaction between advisory committees and stakeholders
- Need more clear communication between DMH and counties from the beginning about the CSS plans

Cultural Competence Issues

- Need more voice and presence of cultural competence in the room, especially Native Americans and Asians, for whom translation would be necessary. This is likely mirrored at county level. The fact of it being a "state meeting" could be intimidating. Need to look at various ways to make it inviting.
- Need to listen to and incorporate feedback from consumers, family members and stakeholder groups, e.g., Native American
- Inclusion of Native American community
- Have State take more leadership and more resources to engage other underserved ethnic populations, in addition to Latinos
- Some cultures do not have a word or notion of recovery. How do we build what is not there?
- Need more MHSA services for different cultures
- Need more outreach to include youth and speakers of other languages and continued focus on cultural competence
- Translate website into different languages, not just English. Information needs to be in different languages.

Age Group Issues

- Need more money for early mental health initiative (EMHI) and the primary intervention program (PIP): build on what is working
- The need for services for transition-age youth and older adults is very great. Involve the community and increase awareness.
- Transition-age youth need more age-appropriate activities
- Transition-age youth outcomes in various areas, such as supportive housing, structure, increase in transition-age youth voices, more agency involvement, and better focus from multi-agency perspective
- Need to get input and involvement of youth through Independent Living Program (ILP)
- Older adult mental health combined with independent living and supportive living

Geographic Isolation Issues

- Greater geographical variance in meeting location for statewide meetings
- Workgroups are not accessible to residents of Southern California
- Disappointed at turnout for Southern California
- Most people are not connected to statewide process: location is an issue
- Hold stakeholder meetings in areas besides Sacramento and Los Angeles, e.g., the Bay Area, Redding and San Diego
- Need to identify which counties are not participating and encourage them to participate

Process Intensity and Scheduling

- Local process and training exhausts the stakeholders. Nothing is left for State process.
- There is so much going on and not enough people to cover all of them
- Timing of stakeholder meetings at local level
- Too many changes to meetings ahead of time and too many cancellations lost some participants

Clarity Needed

- Find data source other than census, which is not reliable
- Confusion between terms “proposals” and “recommendations”
- There is confusion about allocation process
- Balance between attention to detail and too complex

Resources Issues

- Increased outreach is bringing people in without enough resources. Small counties cover large geographic areas without the ability to cover the whole area.
- Small counties do not have a sizeable amount of funding to take action
- Transportation is still an issue
- There is a lot of focus on the money; a feeling that there is not enough and this can stall the process. People focus on the money and do not continue to look forward.

Community Education/Promotion Issues

- Publicize the 800 number
- Community education with anti-stigma messages
- Educating teachers and administrators is a huge need

Evaluation Issues

- Need to develop ways to assess the effectiveness of training
- Can we hear from outcome/performance measure experts about what works–what kinds of outcomes are more statistically significant–expertise from universities, researchers, etc?
- There needs to be continued involvement and improvement of the process at the county level

3. How can annual CSS updates be used to maintain the momentum of the MHSA moving forward?

Specific Measures/Criteria

- Use the DMH-developed five values as a measure for future updates
- Keep focused on five critical points with fidelity to the model
- Transportation for those who are unable to access services
- Better outreach
- Tangible outcomes like people being housed, getting jobs, in out-of-home placements, etc
- Measure success with vignettes and data: how many people were reached with full service partnerships? These are all important.
- Transformation in regards to employment needs to include consideration of employment of seniors
- Analyze what is appropriate staff: client ratio by population type
- Assess new ways to include consumers and family members
- Is this system truly more usable? Find ways to measure this feedback from providers.
- What effect has more culturally competent staff had on outcomes?
- Recipients need to show education and training in recovery. Demonstrate they are actually training people.
- Interview all counties to determine how many consumers were truly involved

Evaluation Issues

- Celebrating successes, start with positive reflections
- Keep documenting and celebrating milestones. More cake!
- Be open and honest about challenges found. Be willing to include some problems.
- Cannot anticipate unforeseen circumstances, e.g., what happened in San Diego
- Assess what is not in the plan
- Quality management: use surveys at county and state level to see how we are doing
- Ensure there is basic summary information available about the annual updates
- Finish up the focus groups and formulate the specifics of the plan
- Discuss improvements and adjustments based on both stakeholder feedback and outcomes
- Evaluate what is working and what is not working. First plan was put out quickly. Many details were not thoroughly thought through.
- How to ensure meeting the needs of the unserved

Stakeholder Involvement in Plan

- Continue to show outreach at all levels, bringing in more diverse and inclusive populations
- Develop best practices for outreach and share information
- Ensure the stakeholder involvement is reported on
- Provide pre-paid postcards at service sites to encourage people to provide feedback

- Expanded size and role of stakeholders: continue to expand to unserved and underserved communities
- Keep promoting access to marginalized populations; create more and continuing opportunities for ongoing engagement at all levels
- Workers and front line staff should be solicited to give their impressions or evaluations of how the process works
- People need to feel an ownership to keep it real, as opposed to tokenism

Dissemination

- DMH should publicize innovative and best practices programs coming out of local process and provide incentives for best practices
- Solicit descriptions of programs of excellence
- Highlight what is successful, small, medium or large
- Provide monetary awards to those programs that are successful
- Put examples of leveraging on the website
- Post outcomes: need to be transparent
- Post county plans and updates for each county on MHSA website
- Better information updates, not just computer or Internet
- Provide information on the county's progress since the last update

Stakeholder Input in Review Process

- Continue to have DMH include stakeholders in the review process who were involved in the initial process. It does not always have to be a meeting.
- Keep initial stakeholders involved. Ask these stakeholders for evaluation of the process.
- Workgroups could work with DMH review staff to determine how the county is doing. DMH staff integration is essential and important so workgroup work is not just used for planning.
- Continue involvement of stakeholders at these annual updates. Do not make this just an internal process.
- Ensure that counties comply with MHSA intent to keep all stakeholders involved in the annual update process
- County oversight of stakeholders (consumers and family members) to monitor CSS plan

Evaluation Methods

- Systematic evaluation: how has policy, procedure, practice or training changed, measures of effectiveness
- Self-evaluation facilitated by someone like John Ott to discuss and reflect on changes
- Each year, upgrade requirements for reporting. Make sure counties have good ideas, then check how it is working.
- Every county should show outcomes measures and associated improvement
- Including outcomes on regular basis is key to making sure transformation is really happening

- Keep focus on outcomes at annual reviews
- Use semi-annual updates
- Conduct internal, inside updates on progress

Consumer and Family Member Input
- Have client and family generated outcomes with some criteria developed by clients, families, and other key stakeholders
- Keep up diversity of client input at county level
- Get consumers and family members' input on an ongoing basis. Make sure these are not just "yes" people.
- Facilitate the inclusion of consumers and family members by providing mass transportation, work subsidies, etc

County Issues
- Ongoing planning and funding for counties
- Continued, ongoing technical assistance and training to counties

Regional Issues
- Hold regional meetings of consumers to provide insight on regional progress, like a report card. Cross fertilize to other counties to promote common vision and accountability.
- Keep encouraging people to contact the 800 number and MHSA email. Provide regional contacts for people.
- With several counties participating, DMH has a great opportunity to continue to facilitate. Bring top leaders of counties together to talk about successes and areas of improvement.
- Try to problem-solve. Keep collaboration among counties and foster a "culture of continuous learning."

Coordination with Other Requirements or Plans
- Merge the cultural competence plan with the CSS plan
- Updates should include a county's five-year plan for improvements
- Bureaucratic process needs to be streamlined

Other
- Keep advocacy organizations strong
- Look at Prop. 10 as model for collaboration
- Keep focus on older adults. Do not forget their interests and needs.

4. What other suggestions do you have to maintain the momentum of the MHSA moving forward?

Community Promotion
- Hold planned celebrations throughout California and make it a media event
- Engage people through an event such as a barbecue at a park

- Get message out to general public to get them involved in how the dollars are making changes, using human interest stories, etc
- Have a forum for consumers and family members to tell their stories
- Involve public figures and celebrities to conduct anti-stigma campaigns
- Include a mental health beat reporter at each county to talk about what was happening in that community
- Use live web sites about what is happening
- Make it more publicly known what is a "stakeholder" so people realize it does apply to them. Make it clear that a stakeholder is anyone who is interested.
- Outreach to general population to combat stigma, using promotion and public service announcements
- Create a documentary about the MHSA process and transformation
- Education on the MHSA is important. When plans are starting to transform, counties need to get the word out.
- DMH might pursue a media campaign to tell people about their successes
- Increased public awareness through public service announcements

Communication Among Stakeholders

- Encourage counties to keep staff, clients and family members informed
- Make sure succinct, basic information is constantly made available to new people participating in the process
- Provide a road map of what is ahead, show how everything works together
- Ask people what they really need
- Make sure DMH has a timeline to provide data back to counties and providers
- People are not aware of process. Help by identifying CBOs. Keep up effort to get clients involved.
- Provide better notice of meetings using computer notice, accessibility to notice, maybe in press, promotions in newspapers. There was not as much notice for this meeting as others.
- Publicize best practices from other counties and share success stories
- Will counties be encouraged to have annual events to report to local stakeholders?
- Hold cluster meetings or regional county meetings for cross-fertilization

Collaboration

- Need to link with childcare centers and partner with First 5
- Target employers for next round of meetings to engage in discussions for workforce development
- Invite any other state departments involved in employment
- Invite organizations that have not been participating
- Include Department of Aging as partner at state and local level. This agency is missing.
- DMH should have contacted Department of Developmental Services (DDS) to establish a partnership, but did not
- DMH needs to develop collaboratives

- All of innovation should go to collaboration. Once collaboration gets going, it is contagious.
- Maintain relationships with new partners

Human Resources and Training
- Small and medium size counties do not have four-year schools and will need graduate students to help with data analysis
- Employ consumers and family members as trainers
- Expand training of stakeholders, county staff, etc
- DMH needs to have regular trainings for individual counties, lawyers or county counsels, so they do not undercut client involvement process as happened in San Diego County
- During application process, emphasize the fact that experience in mental health is not a prerequisite for employment
- Support Oversight and Accountability Commission with staff and other resources

Client and Family Member Input
- Keep inclusion of clients and family members
- Go out to the people in need, create a bond and talk to them on their own turf
- Stanislaus County's co-location of consumer services with the Mental Health administration helps to ensure that consumer voices are heard
- People with physical disabilities have felt that they were not included

Stakeholder Input
- Ensure that DMH and counties are constantly thinking of ways to include new people with fresh perspectives, among professionals, consumers and family members
- Hear from the providers about what is working well. Success stories and practical information for how to implement can inspire people.
- When people feel involved, the momentum will be sustained

Funding and Program Concerns
- Need more flexibility on start-up funds
- Providers need dedicated funds/resources to organize (and support) their consumers (especially those not part of the mainstream)
- Build on what is working: there are good programs out there that need more funding
- Need programs for children with incarcerated parents and for post traumatic stress disorder (PTSD) treatment
- Make sure resources, including people, are accessible

F. Constituency Outreach and Education Collaborative (COEC)

An overview of the Constituency Outreach and Education Collaborative (COEC) was provided. As part of DMH's 5% administration allocation, the Department made a joint grant to the four advocacy groups: the California Network of Mental Health Clients (Client Network), the Mental Health Association of California (MHAC), National Association for the Mentally Ill – California (NAMI) and United Advocates for Children of

California (UACC). Their task is to develop and implement a training curriculum and process to conduct outreach to encourage people to participate in the county stakeholder processes. The trainings will focus on outreach to the underserved and unserved who do not trust government enough to participate in services or planning processes. This includes, but is not limited to transition-age youth and the gay, lesbian, bisexual and transgender community.

COEC plans to work with consumers and family members on a county-by-county basis, finding out what they need to meet their own objectives. The grant from DMH will extend a similar grant awarded to MHAC by The California Endowment to work with Alameda, Fresno, Los Angeles and San Diego counties. DMH's grant will fund training for four additional counties. Four counties in Northern California have expressed an interest, but a maximum of three will be chosen, leaving resources for a Southern California county.

Representatives from the four advocacy groups described the process of working together. Each stated that it has been a growth experience, learning to mediate their different core philosophies, constituencies, goals and objectives. COEC provides an opportunity for the advocacy groups to work together on outreach to under-represented people. For example, the Client Network has formed a statewide team, named the California Clients Diversity, Outreach and Inclusion Team (DOIT). It has selected contacts in the four target counties so that residents will have long-term contacts. As the COEC spreads to other counties, they will develop contacts there. It is vital that the local people know their local contacts. The focus for the DOIT team is to: 1) talk about the MHSA from the client perspective and principles and 2) provide people with information that will enable them to have input into the process.

UACC representatives noted that they have learned that it is complicated to do outreach, especially to communities that have traditionally been excluded. At the end of the process, not only will COEC have spent time educating these communities to participate in policy in their counties, it will understand what is really needed to do outreach in California effectively.

Stakeholder Questions and Comments

- Can Riverside County be the Southern California county?
  - ***COEC Response:*** The Director of Community Mental Health has to request participation.

- What does COEC do specifically?
  - ***COEC Response:*** First the collaborative is laying the groundwork to identify the local groups. Then it is putting together one event in each county. The first event will be held in Fresno targeting the Southeast Asian community. We will provide general information for everyone attending. We will have an opportunity to learn the needs in their specific community. We will offer peer support from the four perspectives represented by COEC members: for clients, family

members of adult clients and family members of children as well as link people with their local advocacy organizations from whom to receive ongoing local support.

- Do counties get credit for this for the stakeholder process?
  - ***COEC Response:*** Yes, they will definitely get credit from DMH toward their community participation for the MHSA. We are not sure how it will work in other counties.

- Can people from nearby counties attend?
  - ***COEC Response:*** Initially COEC is targeting specific counties and populations within those counties. Later we hope to take a more regional approach.

- I am concerned about the project process and want to see it get off the ground. It seems that the counties you are currently working with already understand the issues and work reasonably well with their constituencies. I am concerned about those counties that are less successful.
  - ***COEC Response:*** The opportunities are definitely there for other counties to participate. We have solicited interest from many counties and we have responded to all the counties who have expressed interest. It is a voluntary training. Because we wanted to leverage the funding, we are working with MHAC's previous grant from The California Endowment.

- How can we contact COEC?
  - ***COEC Response:*** COEC can be contacted through each of the advocacy groups. Brochures were sent to all counties. If you think you would be interested, do not hesitate to contact any of the collaborative members.

G. Network of Care Update, Demonstration and Discussion

Another of the initiatives funded through DMH's MHSA administration funding is the Network of Care, which was originally funded by the Department of Aging. Dr. Mayberg gave a grant to San Diego County for the Network of Care to add a mental health component. DMH and San Diego County have been so impressed with the pilot that MHSA funding is being used to develop a Network of Care site for each California county and to pay for the first year's maintenance fees. The San Diego site was developed with considerable consumer and family member involvement, to make sure it was responsive to their needs. The website address is http://networkofcare.org.

A demonstration of the site's abilities was provided by Bob Egnew, a former county mental health director and a principal of Trilogy Integrated Resources, the software developers of the Network of Care. Trilogy Integrated Resources was founded by former State Assembly Member Bruce Bronzan and Afshin Khosravi.

Dr. Mayberg asked Mssrs. Bronzan and Khosravi to make a well-received presentation to the President's New Freedom Commission. It was mentioned in the report as a

model program. As a result, the Network of Care is now available in fourteen states. SAMHSA plans to fund 25 sites in the country.

Mr. Egnew showed the highlights of the site. The site has no e-commerce ads. The first counties to have individualized sites are Fresno, Los Angeles, San Diego and San Mateo.

He noted that it could be viewed in text-only format, which was approved by the Americans with Disabilities Act for the visually impaired. It could also be used for machine translations into virtually any language. These permit translation of the entire website into most languages. It can also be used by web-enabled cell phones, which may be helpful for outreach and peer-support workers.

Each individual county site can include a community news section. San Diego chose to use theirs to provide detailed information about their MHSA stakeholders' process. The county mental health department can incorporate any news or updates it chooses.

There is also a section of nationwide news, using a service which combs through 2,000 periodicals every day and then puts the top two news articles on the site. These articles are then archived to be available later.

Channels for Information

- **Service,** specific to each county, lists all the mental health services and supports available in the county. Searches can be conducted in a number of ways: by category of service, program name, key word, and advanced search for a number of parameters. This section includes a map, driving directions, public transportation options and more detailed information about the services, including hours, age groups and specific services.

- **Library** is the largest internet library on mental health on the Web with more than 35,000 articles. In addition, the California Institute for Mental Health (CIMH) translated twelve articles about the most common mental health disorders into six main languages, with a telephone number to reach someone who speaks the language. These are very clearly written at a ninth- to tenth-grade level. There is a section on medication, which includes every medication approved by the FDA. The tool includes important information one should know about medication; what the medication is, what should be discussed with one's health care provider before taking it; how to take it; what happens in case of overdose; what should be avoided while on the medication; possible side effects; other drug interactions; where to get more information; and what the medication looks like. Medications are listed by both brand and generic names. Information is updated every thirty days. If there are recalls or other emergencies, this information appears immediately.

- **Legislate** channel provides a summary of every bill concerning mental health in the California legislature and U.S. Congress. It also has a tool to allow users to contact

their legislator(s) by email, as well as any legislative committee at the state or federal level.

- **Links,** specific to each county, includes all the links in the area, region and nation on specific mental health issues. It provides the opportunity for people to provide the Network of Care with additional links which will then be checked and added, as appropriate.

- **Insurance,** specific to each county, provides information about each insurance company that writes policies in the county, and includes information about price and mental health benefits.

- **Support and Advocacy,** specific to each county, includes links to all support and advocacy groups in the county and nation that address mental health issues.

- **My Folder** is an encrypted folder into which a user can place any information from the site as well as emergency contact information. People create their own login and password. People can allow specific people to access it or can keep it entirely to themselves.

It is also possible, with minimal help and a few hours, for support groups to build their own website from the Network of Care website.

The Network of Care is developing a channel specific for recovery and wellness. Currently the information is spread throughout the website, but the new channel will allow more focused attention to this important issue. SAMHSA is helping to develop this area. It is not part of what the MHSA is funding, but California users will have access to it.

Stakeholder Questions and Comments

- Who gathers the information for each county's site?
  - ***Trilogy Response:*** Trilogy does, working with the county mental health department. If a resource is not on the site, there is an opportunity for users to provide feedback, which Trilogy will investigate and forward to the county mental health department for approval for inclusion.

- Will you include information about Medicare prescription benefits?
  - ***Trilogy Response:*** Yes. This will include an analysis based on which medications a person takes. This is expected to be uploaded within the next two weeks.

- How is My Folder different from putting the information on one's hard disk?
  - ***Trilogy Response:*** The folder is encrypted and people can share some or all of their information. You can list your doctors, you can send your doctor a message and the doctor can reply to you into your encrypted folder.

- How is it being paid for?
  - ***Trilogy Response:*** In California, DMH is paying for the set-up and first year maintenance for each county. Then it will be up to the counties to pay for continuation of the service.

- Will the site include information about drugs and alcohol?
  - ***Trilogy Response:*** Yes.

- Can you work with the California Office of Self-Help for developing the Recovery channel?
  - ***Trilogy Response:*** Numerous consumers are involved in its development. It will have a library dealing with recovery issues, emerging practices, annual survey of state practices, trends in the field, case studies, a section on recovery tools, a consumer corner where people can chat about recovery, a distance learning channel, as well as nationwide and local news about recovery.

- Why have you not included California consumers in the planning of the Recovery channel or development of the site overall?
  - ***Trilogy Response:*** We have done so, especially in San Diego. The Recovery channel is a nationwide effort funded by SAMHSA.

- Recognizing the leaders of the recovery movement in California, should there not be some involvement from these leaders?
  - ***Trilogy Response:*** The Recovery channel is a national component with a national consumer advisory group. It will be available to each county in the state.

- There is a wellness and recovery task force in the Client Network. These people should be included.
  - ***Trilogy Response:*** We will contact the Client Network.

- Why is DMH not using a nonprofit organization for cost-effectiveness?
  - ***Trilogy Response:*** DMH chose Trilogy because the product is already established. The Network of Care was not created for the MHSA; it is something the MHSA is purchasing because of its proven success.
  - ***DMH Response:*** The Network of Care has a basic framework, which DMH asked to be customized for California counties. DMH did not pay Trilogy to redesign their basic system. We have not asked them to make this specific to California.

- How much adapting will be done after the beta site?
  - ***Trilogy Response:*** All of Trilogy changes over time based on feedback.

- Do you know how many people use this?
  - ***Trilogy Response:*** We know where people go on this site, not what they do there.

- How does information get to the website for a county?
  - ***Trilogy Response:*** The county department sends the information using a computer or hard copies. People can send in additional information by email or through the feedback tool.

- What is the cost?
  - ***Trilogy Response:*** DMH is paying for the first year's set-up and maintenance fees. The county is responsible for future years. Counties belonging to the National Association of County Behavioral Health Directors will get a discount. The price varies with the size and complexity of the county. For example, maintenance costs about $45,000 for a county the size of Orange County.

- This is very different from a resource book that is outdated by the time it is printed.
  - ***Trilogy Response:*** This is a living, breathing document.

- How does that updating happen?
  - ***Trilogy Response:*** Counties need to provide this information. They generally have a contact person. The initial set-up is intensive, but the rest is minimal.

- Do you have a glossary that can be tailored to a specific county?
  - ***Trilogy Response:*** We can probably create that for specific counties.

- Is this accessible to the general public?
  - ***Trilogy Response:*** Yes. However, in California, it will be available in every county. We will help each county do a major launch. This allows counties to communicate with everyone.

- MHSA should help make the Network of Care accessible to nonprofits serving clients who do not have computers.